

TSSAA PREPARTICIPATION EVALUATION

HISTORY FORM

DATE OF EXAM: _____

NAME: _____ SEX: _____ AGE: _____ DATE OF BIRTH: _____

GRADE: _____ SCHOOL: _____ SPORT(S): _____

HOME ADDRESS: _____ HOME PHONE: _____

PERSONAL PHYSICIAN: _____

EXPLAIN "YES" ANSWERS BELOW. CIRCLE QUESTIONS YOU DON'T KNOW THE ANSWERS TO.

- | | |
|---|--|
| <p>1. Has a doctor ever denied or restricted your participation in sports for any reason? Y N</p> <p>2. Do you have an ongoing medical condition (like diabetes or asthma)? Y N</p> <p>3. Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills? Y N</p> <p>4. Do you have allergies to medicines, pollens, foods, or stinging insects? Y N</p> <p>5. Have you ever passed out or nearly passed out DURING exercise? Y N</p> <p>6. Have you ever passed out or nearly passed out AFTER exercise? Y N</p> <p>7. Have you ever had discomfort, pain, or pressure in your chest during exercise? Y N</p> <p>8. Does your heart race or skip beats during exercise? Y N</p> <p>9. Has a doctor ever told you that you have:
High Blood Pressure Y N
High Cholesterol Y N
A heart murmur Y N
A heart infection Y N</p> <p>10. Has a doctor ever ordered a test for your heart? (for example, ECG, echocardiogram) Y N</p> <p>11. Has anyone in your family died for no apparent reason? Y N</p> <p>12. Does anyone in your family have a heart problem? Y N</p> <p>13. Has any family member or relative died of heart problems or of sudden death before age 50? Y N</p> <p>14. Does anyone in your family have Marfan Syndrome? Y N</p> <p>15. Have you ever spent the night in a hospital? Y N</p> <p>16. Have you ever had surgery? Y N</p> <p>17. Have you every had an injury, like a sprain, muscle or ligament tear, or tendonitis, that caused you to miss a practice or game? Y N
If Yes, explain: _____</p> <p>18. Have you had any broken or fractured bones or dislocated joints? Y N
If Yes, explain: _____</p> <p>19. Have you ever had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches? Y N
If Yes, explain: _____</p> <p>20. Have you ever had a stress fracture? Y N</p> <p>21. Have you been told that you have or have had an x-ray for atlantoaxial (neck) instability? Y N</p> <p>22. Do you regularly use a brace or assistive device? Y N</p> | <p>23. Has a doctor ever told you that you have asthma or allergies? Y N</p> <p>24. Do you cough, wheeze or have difficulty breathing during or after exercise? Y N</p> <p>25. Is there anyone in your family who has asthma? Y N</p> <p>26. Have you ever used an inhaler or taken asthma medicine? Y N</p> <p>27. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ? Y N</p> <p>28. Have you had infectious mononucleosis (mono) within the last month? Y N</p> <p>29. Do you have rashes, pressure sores, or other skin problems? Y N</p> <p>30. Have you ever had a herpes skin infection? Y N</p> <p>31. Have you ever had a head injury or concussion? Y N</p> <p>32. Have you been hit in the head and been confused or lost your memory? Y N</p> <p>33. Have you ever had a seizure? Y N</p> <p>34. Do you have headaches with exercise? Y N</p> <p>35. Have you ever had numbness, tingling or weakness in your arms or legs after being hit or falling? Y N</p> <p>36. Have you ever been unable to move your arms or legs after being hit of falling? Y N</p> <p>37. When exercising in the heat, do you have severe muscle cramps or become ill? Y N</p> <p>38. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease? Y N</p> <p>39. Have you had any problems with your eyes or vision? Y N</p> <p>40. Do you wear glasses or contact lenses? Y N</p> <p>41. Do you wear protective eyewear, such as goggles or a face shield? Y N</p> <p>42. Are you happy with your weight? Y N</p> <p>43. Are you trying to gain or lose weight? Y N</p> <p>44. Has anyone recommended you change your weight or eating habits? Y N</p> <p>45. Do you limit or carefully control what you eat? Y N</p> <p>46. Do you have any concerns that you would like to discuss with a doctor? Y N</p> <p>FEMALES ONLY</p> <p>47. Have you ever had a menstrual period? Y N</p> <p>48. How old were you when you had your first menstrual period? _____</p> <p>49. How many periods have you had in the last 12 Months? _____</p> <p>Explain "Yes" answers here: _____

_____</p> |
|---|--|

I herby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Athlete's Signature: _____ Parent/Guardian Signature: _____ Date: _____

Questions taken from American Academy of Family Physicians, American Academy of Pediatrics, American College of Sports Medicine, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine, & American Orthopaedic Academy of Sports Medicine 2004 PPE Form.

TSSAA PREPARTICIPATION EVALUATION

PHYSICAL EXAMINATION FORM

NAME: _____ DATE OF BIRTH: _____ SCHOOL: _____

HEIGHT: _____ WEIGHT: _____ % BODY FAT (OPT.): _____

PULSE: _____ BP: _____/_____/_____ (_____/_____, ____/____)

VISION R 20/_____ L 20/_____ CORRECTED: Y N PUPILS: EQUAL _____ UNEQUAL _____

Follow-Up Questions on More Sensitive Issues

1. Do you feel stressed out or under a lot of pressure?..... Y N
2. Do you ever feel so sad or hopeless that you stop doing some of your usual activities for more than a few days?..... Y N
3. Do you feel safe? Y N
4. Have you ever tried cigarette smoking, even 1 or 2 puffs? Do you currently smoke? Y N
5. During the past 30 days, did you use chewing tobacco, snuff, or dip? Y N
6. During the past 30 days, have you had at least 1 drink of alcohol? Y N
7. Have you ever taken steroid pills or shots without a doctor's prescription? Y N
8. Have you ever taken any supplements to help you gain or lose weight or improve your performance? Y N
9. Questions from the Youth Risk Behavior Survey (<http://www.cdc.gov/HealthyYouth/yrbs/index.htm>) on guns, seatbelts, unprotected sex, domestic violence, drugs, etc. Y N

Notes: _____

	NORMAL	ABNORMAL FINDINGS	INITIALS*
MEDICAL			
Appearance			
Eyes/ears/nose/throat			
Hearing			
Lymph nodes			
Heart			
Murmurs			
Pulses			
Lungs			
Abdomen			
Genitourinary (males only)**			
Skin			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand/fingers			
Hip/thigh			
Knee			
Leg/ankle			
Foot/Toes			

*Multiple-examiner set-up only. **Having a third party present is recommended for the genitourinary examination.

Notes: _____

Name of physician (print/type): _____ Date: _____

Address: _____ Phone: _____

Signature of physician: _____, MD or DO

TSSAA PREPARTICIPATION EVALUATION

CLEARANCE FORM

NAME: _____ SEX: _____ AGE: _____ DATE OF BIRTH: _____

GRADE: _____ SCHOOL: _____

_____ Cleared without restriction

_____ Cleared, with recommendations for further evaluation or treatment for: _____

_____ Not cleared for _____ All sports _____ Certain Sports: _____ Reason: _____

Recommendations: _____

EMERGENCY INFORMATION

Allergies: _____

Other Information: _____

IMMUNIZATIONS (eg, tetanus/diphtheria; measles, mumps, rubella; hepatitis A, B; influenza; pneumococcal; meningococcal; varicella)

_____ Up to date (see attached documentation) _____ Not up to date Specify _____

Name of physician (print/type): _____ Date: _____

Address: _____ Phone: _____

Signature of physician: _____, MD or DO

Adapted from American Academy of Family Physicians, American Academy of Pediatrics, American College of Sports Medicine, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine, & American Ortheopathic Academy of Sports Medicine 2004 PPE Form.

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Name of physician (print/type): _____ Date: _____

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I. EMERGENCY TREATMENT

To All Parents:

Since the malpractice question has come to the forefront, many hospitals and doctors will not treat a child without parent's consent (unless a matter of life or death). It is requested that you complete the information below so that if your child requires a visit to the hospital while under the supervision of the school, this will allow the hospital to treat the injury.

EMERGENCY INFORMATION

Name: _____ Sport: _____ Sex: M _____ F _____

Grade: _____ Age: _____ Date of Birth: ____/____/____

Parent's Name: _____

Work Address: _____

Phone Number: _____

Home Address: _____

Phone Number: _____

Another Person to Contact: _____

Relationship: _____ Phone Number: _____

Insurance Name: _____

Policy and Group Numbers: _____

ALLERGIES: _____

Consent Statement: Authorizing Treatment

Parent's Signature: _____

Student's Signature (if over age 18): _____

II. PARENT'S CONSENT

I hereby give my consent for _____ to represent
(Name of Student)
_____ in the sport of _____.
(Name of School)

Date: _____ Signature: _____

MED-02

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

I, _____ (*student name*) (“Student”), and my parents/ legal guardians/ adults responsible for my care (“responsible adult”) (*circle the one that is applicable*), _____ (*parent/legal guardian/responsible adult name*) and _____ (*parent/legal guardian/responsible adult name*), hereby authorize Fort Sanders-Sevier Medical Center and its athletic trainers to disclose to the Sevier County School System coaches, athletic staff, and any other person involved in the operation, administration, or management of the Sevier County Board of Education sanctioned extracurricular sports programs at _____ (*school attending*), as well as Student’s parents/ legal guardians/ responsible adults, any medical or health information relevant to Student’s involvement or participation in such extracurricular sports programs. Such disclosure shall be for the purpose of communicating Student’s ability to participate or continue participation in an extracurricular sports program, including whether Student has suffered any injury, the extent of such injury, the impact such injury could make on continued participation, whether Student’s condition requires further treatment, and whether there should be any adjustment to Student’s participation in such extracurricular sports programs in the Sevier County School System. This authorization shall terminate when the season for the extracurricular sports program in which Student is participating ends, including any post-season (e.g., tournament) play. The undersigned have the right to revoke this authorization at any time by providing the Fort Sanders-Sevier Medical Center Privacy Officer notice in writing. Exceptions to this right of revocation and a description of how this authorization may be revoked are contained in the Fort Sanders Sevier Medical Center Notice of Privacy Practices. Fort Sanders-Sevier Medical Center's athletic trainers will not condition treatment on whether this authorization is signed; however, the Sevier County School System will not permit any student to participate in any extracurricular sports games or tournament play attended by an athletic trainer if the student and his/her parents/legal guardians/responsible adults have not signed an authorization. The undersigned understands and agrees that medical or health information disclosed by Fort Sanders-Sevier Medical Center or its athletic trainers pursuant to this authorization may be subsequently disclosed by the recipient and may no longer be protected by applicable law.

In addition to the foregoing, the undersigned hereby acknowledges receipt of Fort Sanders-Sevier Medical Center's Notice of Privacy Practices.

Student Signature

Date

Parents/Legal Guardian/Responsible Adult

Date

Parents/Legal Guardian/Responsible Adult

Date



INTERSCHOLASTIC SPORTS EXAMINATION

Name _____ Sex _____

Age _____ Date of Birth _____ Grade _____

This athlete is:

- Cleared without restriction
- Cleared, **with recommendations** for further evaluation or treatment for:

- Not cleared for:
 - All sports
 - Certain sports: _____

Reason: _____

Recommendations: _____

EMERGENCY INFORMATION
 Allergies: _____
 Other information: _____

IMMUNIZATIONS
 (Tetanus/diphtheria, MMR, Hepatitis A, Hepatitis B, Influenza, Polio, Pneumococcal, Meningococcal, Varicella)
 Up to date Not up to date (Specify: _____)

WELL CHILD CHECK/EPSDT
 Has completed well child exam/EPSDT screen (required for 7th and 9th grade athletes)

Name of Provider (print/type): _____

Office Address: _____

Office Phone: (_____) _____

Signature of Provider: _____ Date: _____